3 Clinic Guidelines

3.1 Mental Health (MH) Clinic Service Policy

3.1.1 Introduction

This section covers all Medicaid services provided by mental health clinics and diagnostic screening clinics as deemed appropriate by the Department of Health and Welfare (DHW). It addresses the following:

- Provider enrollment and credentialing.
- Psychotherapy and diagnostic screening.
- Record keeping.
- Covered services.
- Exclusions.
- Reporting requirements.
- Claims payment.
- Claim billing.

3.1.2 Overview

The MH Clinic Program is designed to promote overall mental wellness for Medicaid participants. In accordance with the Federal Code of Regulations 42 CFR 440.90, all MH clinic services must be provided at the clinic, unless provided to an eligible homeless individual per regulations. Services provided outside of the clinic facility are not reimbursable by Medicaid. Clinic services are typically preventative, diagnostic, therapeutic, rehabilitative, or palliative services. Recreational, educational, and vocational services are not Medicaid-covered MH clinic services.

3.1.2.1 Provider Enrollment and Credentialing

In order to become enrolled as a Medicaid mental health clinic provider, the provider applicant must meet the requirements established through the credentialing program as identified in *IDAPA 16.03.09.712 Mental Health Clinics Services – Credentialing Responsibilities of the Department*. All existing MH clinic providers must meet the requirements of the credentialing program on a schedule established by DHW.

All locations where Medicaid MH clinic services are provided must be registered with DHW and must have a valid Provider Agreement. Mental health clinics are no longer allowed to bill for services provided at another location under their main clinic number. Each location must obtain its own provider number.

3.1.2.2 Physician Requirement

All MH clinics must have a contract with a medical doctor or doctor of osteopathy in which the doctor agrees to the following:

- See the participant at least once in order to determine medical necessity and appropriateness of clinic services; see *IDAPA 16.03.09.714.03.b Mental Health Clinic Services - Provider Agency Requirements; Physician Requirement for Supervision of a Participant's Care.*
- Review and sign the treatment plan within 30 days of initiation of treatment and all treatment plan reviews, see *IDAPA 16.03.09.714.03.d Mental Health Clinic Services - Provider Agency Requirements; Physician Requirement for Supervision of a Participant's Care.*
- Provide overall clinic supervision, as indicated in *IDAPA 16.03.09.714.02 Physician Requirement for Clinic Supervision,* and agree to spend as much time in the clinic as is necessary to assure that all participants are receiving services in a safe and efficient manner in accordance with accepted standards of medical practice.

3.1.2.3 Evaluative or Diagnostic Services

Twelve hours of evaluative, or diagnostic services and treatment plan development are payable, per calendar year, per eligible participant.

Note: Medicaid Basic Plan participants are limited to 26 services for all outpatient MH services combined, per calendar year. The 12 hours of evaluative or diagnostic services count towards the 26 service limitation.

3.1.2.4 Psychotherapy

Psychotherapy services include individual, group, or family psychotherapy and emergency psychotherapy services. For Medicaid Enhanced Plan participants, psychotherapy services are limited to no more than 45 hours, per calendar year, per participant.

Note: Medicaid Basic Plan participants are limited to 26 services for all outpatient MH services combined.

3.1.2.5 Interactive Psychiatric Diagnostic Interview Examinations and Interactive Psychotherapy

Interactive psychiatric diagnostic interview examinations and interactive psychotherapy are typically furnished to children. They involve the use of physical aids and non-verbal communication methods to overcome barriers to therapeutic interaction between the clinician and a participant. They are used when the participant has not yet developed, or has lost, either the expressive language communication skills to explain their symptoms and response to treatment, or the receptive communication skills to understand the clinician if they were to use ordinary language for communication.

Note: Medicaid Basic Plan participants are limited to 26 services for all outpatient MH services combined.

3.1.3 Partial Care

Partial care is clinic-based treatment for those children with serious emotional disturbance and adults with severe and persistent mental illness whose functioning is sufficiently disrupted so as to interfere with their productive involvement in daily living. In order to be eligible for partial care services, the comprehensive assessment must contain documentation showing that the participant is presently at risk for an out-of-home placement, or clinical deterioration that would lead to an out-of-home placement, or clinical deterioration which would interfere with the participant's ability to maintain their current level of functioning. See *IDAPA 16.03.10.112 Enhanced Outpatient Mental Health Services - Participant Eligibility.*

Partial care services consist of structured programs of therapeutic interventions that assist a program participant to stabilize their behavior and conduct. This is accomplished through the application of principles of behavior modification for behavioral change and structured, goal-oriented group socialization for skill acquisition. The goal of partial care services is to decrease the severity and acuity of presenting symptoms so that the participant may be maintained in the least restrictive setting and to increase the participant's interpersonal skills in order to obtain the optimal level of interpersonal adjustment.

Partial care services are payable up to a maximum of 12 hours, per week, per eligible participant. Partial care (day treatment) services must be provided at the clinic by qualified staff listed in *IDAPA 16.03.09.715.01 Mental Health Clinic Services - Agency Staff Qualifications; Staff Qualifications.* This list does not include support staff. Mental health clinic providers may elect to employ support staff to provide support services to participants. Such support services may include providing transportation, cooking and serving meals, cleaning and maintaining the physical plant, or providing general, non-professional supervision. Clinical services shall not be provided by students, aides, or support staff and their services are not reimbursable by Medicaid.

Note: Partial care services are covered only for Medicaid Enhanced Plan participants who meet criteria specific to partial care. See *IDAPA 16.03.10.112 Enhanced Outpatient Mental Health Services - Participant Eligibility*.

3.1.4 Collateral Contact

Contact may be billed as collateral contact when it is necessary to provide consultation or treatment direction about a Medicaid participant to an individual having a primary treatment relationship to the participant. The need for collateral contact should be clearly reflected in the participant's written treatment plan. The service must be:

- Conducted by agency staff qualified to deliver clinical services.
- Authorized on the treatment plan.
- Documented in the progress notes.
- Face-to-face or may be by telephone if that is the most expeditious and effective way to exchange information.

Collateral contact cannot be used to bill Medicaid for therapy to an ineligible person or be paid on behalf of an individual who is a resident of a public institution or a nursing home including an intermediate care facility (for developmentally disabled)/mentally retarded (ICF/MR). Medicaid does not reimburse for parent education and/or parent support groups.

Note: Services not approved in the treatment plan or documented as indicated in, *Section 3.1.6 Record Keeping*, will not be reimbursed by Medicaid.

3.1.5 Exclusions

Mental health clinic services are not reimbursable when provided in an institution; when performed by a non-qualified staff person; or when not adequately documented in the participant's record.

3.1.6 Record Keeping

Each MH clinic is required to maintain medical records on all services provided to Medicaid participants. The record must contain a current treatment plan based on an individual assessment of the participant's needs and signed by a physician within 30 days of the initiation of treatment in the clinic.

Services must be provided in accordance with the current treatment plan, and the records must contain all of the following:

- The exact type of treatment provided.
- Who provided the treatment.
- The duration of the treatment and the start time and stop time of day delivered.
- Detailed records of exactly what occurred during the therapy session or participant contact documented by the person who delivered the service.
- The legible, dated signature, with degree credentials listed of the staff member performing the service.

Any service not adequately documented in the participant's record, by the signature of the therapist providing the therapy or participant contact, the length of the therapy session, and the date of the contact, will not be reimbursed by DHW.

3.1.7 Determining How to Bill Units for 15 Minute Timed Codes

Several CPT codes used for evaluations, therapy modalities, procedures, and collateral contacts specify that one unit equals 15 minutes. Provider's bill procedure codes for services delivered using CPT codes and the appropriate number of units of service. For any single CPT code, providers bill a single 15 minute unit for treatment greater than or equal to eight minutes. Two units should be billed when the interaction with the participant or collateral contact is greater than or equal to 23 minutes to less than 38 minutes.

Time intervals for larger numbers of units are as follows:

3 units ≥ 38 minutes to < 53 minutes

4 units ≥ 53 minutes to < 68 minutes

5 units ≥ 68 minutes to < 83 minutes

6 units ≥ 83 minutes to < 98 minutes

7 units ≥ 98 minutes to <113 minutes

8 units ≥ 113 minutes to < 128 minutes

The pattern remains the same for treatment times in excess of 2 hours. Providers should not bill for services performed for less than eight minutes. The expectation (based on work values for these codes) is that a provider's time for each unit will average 15 minutes in length.

The above schedule of times is intended to provide assistance in rounding time into 15 minute increments for billing purposes. It does not imply that any minute until the eighth should be excluded from the total count as the timing of active treatment counted includes all time. The beginning and ending time of the treatment must be recorded in the participant's medical record with the note describing the treatment. (For additional guidance please consult CMS Program Memorandum Transmittal AB-00-14.)

3.1.8 Billing Procedure for Date Spanning

The dates of service billed on a single detail line must be within the Sunday through Saturday calendar week. Consecutive dates of service that fall in one calendar week (Sunday through Saturday) can be billed on one detail line. When date spanning, services must have been provided for every day within that span. It is incorrect to date span the entire week when services were only performed on Wednesday and Friday.

Example:

Services provided to the participant on:

- Wednesday, December 11, 2008
- Friday, December 13, 2008

Enter each date on a separate detail line.

Date(s) of Service	Procedure Code	Charges
12/11/2008 – 12/11/2008	XXXXX	$XXX.XX
12/13/2008 – 12/13/2008	XXXXX	$XXX.XX

3.1.9 Procedure Codes

Idaho Medicaid uses the following 5-digit codes for MH clinic services:

Service	CPT or HCPCS	Description
Diagnosis and Evaluation		
Medical report based on new exam	**90889**	Preparation of report on participant's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers. This may be billed by: Physician, nurse practitioner, physician assistant, psychiatric nurse practitioner, or clinical nurse specialist-psychiatric. Bill with appropriate MH diagnosis. Reimbursed per report.

Service	CPT or HCPCS	Description
Medical report on past record, rather than new exam	**90885**	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric, and/or projective tests, and other accumulated data for medical diagnostic purposes. This service may be billed by: Physician, nurse practitioner, physician assistant, psychiatric nurse practitioner, or clinical nurse specialist-psychiatric. Must use appropriate MH diagnosis. Reimbursed per report.
Psychiatric diagnostic interview, exam	**90801** **U1** Modifier is required when provided by physician	Psychiatric diagnostic interview examination. This service may be billed by: Physician, nurse practitioner, physician assistant, psychiatric nurse practitioner, clinical nurse specialist-psychiatric, psychologist, licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist. 1 Unit = 15 Minutes.
Interactive medical psychiatric diagnostic interview, exam	**90802** **U1** Modifier is required when provided by physician	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication. This service may be billed by: Physician, nurse practitioner, physician assistant, psychiatric nurse practitioner, clinical nurse specialist-psychiatric, psychologist, licensed clinical social worker, licensed clinical professional counselor, or licensed marriage and family therapist. 1 Unit = 15 Minutes.
Social history and evaluation	**T1028**	Assessment of home, physical, and family environment, to determine suitability to meet patient's medical needs. Also referred to in rule as social history. This service may be performed by a licensed social worker or nurse as well as other qualified clinical staff. This code should be used as part of the initial intake only. It is not considered to be an ongoing service. 1 Unit = 15 Minutes.
Psychological testing for diagnosis and evaluation	**96101**	Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, *e.g.*, WAIS, Rorschach, MMPI) per hour of the psychologist's or physician's time, both face-to-face time with the patient, and time interpreting test results and preparing the report. 1 Unit = 1 Hour.
Psychological testing for diagnosis and evaluation	**96102**	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality, and psychopathology, *e.g.*, MMPI and WAIS), with qualified healthcare professional interpretation and report, administered by technician, per hour of technician time, face-to-face. 1 Unit = 1 Hour.
Psychological testing for diagnosis and evaluation	**96103**	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality, and psychopathology, *e.g.*, MMPI), administered by computer with qualified healthcare professional interpretation and report. 1 Unit = 1 Test.

Service	CPT or HCPCS	Description
Individual and Group Psychotherapy		
Individual medical psychotherapy	**90804** **90806** **90808** **UA** Modifier is required when provided by physician	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 – 30 minutes face-to-face with the patient (**90804**). The codes are based on length of time spent with the participant. Providers should select the code that is closest to duration of the session and bill the code as 1 unit. **90804** = 20 – 30 Minutes; **90806** = 45 – 50 Minutes; **90808** = 75 – 80 Minutes. **Note:** Medicaid does not reimburse for documentation time.
Group medical psychotherapy	**90853** **U1** Modifier is required when provided by physician	Group psychotherapy (other than of a multiple-family group). 1 Unit = 15 Minutes.
Family medical psychotherapy	**90847** **U1** Modifier is required when provided by physician	Family psychotherapy (conjoint psychotherapy) (with patient present). 1 Unit = 15 Minutes.
Family medical psychotherapy without participant present	**90846** **U1** Modifier is required when provided by physician	Family psychotherapy (without patient present). Must be face-to-face with at least one family member present. The participant must be the focus of services. Goals of treatment must be specified on the participant's individualized treatment plan. 1 Unit = 15 Minutes.
Interactive individual medical psychotherapy	**90810** **90812** **90814** **UA** Modifier is required when provided by physician	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 - 30 minutes face-to-face with the patient (**90810**). The codes are based on length of time spent with the participant. Providers should select the code that is closest to the duration of the session and bill the code as 1 unit. **90810** = 20 - 30 Minutes; **90812** = 45 - 50 Minutes; **90814** = 75 - 80 Minutes. **Note:** Medicaid does not reimburse for documentation time.
Interactive group medical psychotherapy	**90857** **U1** Modifier is required when provided by physician	Interactive group psychotherapy. 1 Unit = 15 Minutes.

Service	CPT or HCPCS	Description
Other Mental Health Codes		
Collateral contact	**90887**	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient. This service is only reimbursed if it will directly benefit the participant and is necessary to gather information or consult with others regarding the participant's treatment and is included on the participant's treatment plan. Can be face-to-face or by telephone if that is the most expeditious and effective way to exchange information. Specify person who attended session and relationship to the participant. 1 Unit = 15 Minutes.
Partial care	**H2014**	Skills training and development. Partial care services are structured program of therapeutic interventions and must be provided at the clinic. This service must be documented on the participant's treatment plan with concrete and measurable goals. 1 Unit = 15 Minutes. **Note:** Partial care services are covered only for Medicaid Enhanced Plan participants.
Mental health assessment	**H0031**	Comprehensive MH assessment, by non-physician. 1 Unit = 15 Minutes.
Treatment plan development	**H0032**	Mental health treatment plan development, by non-physician. The individualized treatment plan must specify the amount, frequency, and expected duration of treatment. All services being provided to the participant, even if another agency is providing those services, must be included on the individualized treatment plan. Limit of two hours, per agency, per year. 1 Unit = 15 Minutes.
Pharmacologic management	**90862**	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy. This may be billed by: Physician, nurse practitioner, physician assistant, psychiatric nurse practitioner, or clinical nurse specialist-psychiatric. 1 Unit = 1 Visit.
Nursing service	**T1001**	Nursing assessment: Evaluation also includes review of lab results, face-to-face physician and/or participant consultation to discuss participant's condition, or face-to-face physician contact to obtain prescription refills. 1 Unit = 15 Minutes. **Note:** All services must appear on treatment plan in order to be reimbursed.
Blood drawing fee	**36415**	Routine venipuncture for collection of specimen(s). 1 Unit = 1 Visit.
Medication injection	**90772**	Therapeutic, prophylactic, diagnostic injection (specify material injected), subcutaneous, or intramuscular. Includes nurse time and administration. 1 Unit = 1 Injection.
Medication supply	**J3490**	Unclassified drugs. Specify medication and dosage. Use of this code requires submission of the National Drug Code (NDC); note the drug code in the comments field of the claim. See *Section 3.1.7.1 Reporting National Drug Code (NDC) for Medications Billed with HCPCS Codes,* for instructions.
Occupational therapy (individual)	**97535**	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment), direct one-on-one contact by provider, each 15 minutes. 1 Unit = 15 Minutes.

Service	CPT or HCPCS	Description
Interpretation Services		
Non-certified, partially certified, and certified	**8296A**	Interpretive services. 1 Unit = 1 hour.
Non-certified, partially certified, and certified	**T1013**	Sign Language Interpretive Services 1 Unit = 15 minutes.

3.1.9.1 Reporting National Drug Code (NDC) for Medications Billed with HCPCS Codes

Professional claims for medications reported with HCPCS codes, must include the appropriate NDC of the medication supplied, units dispensed, and basis of measurement for each medication. This requirement applies to cancer drugs with HCPCS codes, on claims submitted electronically and on the paper CMS-1500 claim form. This requirement also applies to Medicare claims which, crossover to Medicaid as the secondary payer.

The HCPCS medications that require NDC information are listed in the current *Healthcare Common Procedure Coding System (HCPCS) Manual; Appendix 3*, alphabetically by both generic, brand, or trade name with corresponding HCPCS codes. Claims with incomplete NDC information will be denied with *EOB 628, NDC required*.

The collection of the NDC information allows Medicaid to collect rebates due from drug manufacturers, resulting in significant cost saving to Idaho's Medicaid Program. This requirement is mandated by the Center for Medicare and Medicaid Services (CMS), which requires all states to develop systems to claim drug rebates when Medicaid pays any portion of a drug claim. See State Medicaid Director Letter #06-016, at: **http://www.cms.hhs.gov/smdl/downloads/SMD071106.pdf**.

Electronic Claims: For professional providers that use the PES billing software (provided by EDS at no cost), a HIPAA compliant field to report the NDC information is included. Providers who are not set up to bill electronically with PES software may contact an EDS provider services representative for more information at:

(208) 383-4310 in the Boise calling area

(800) 685-3757 (toll free)

To enter NDC data in the PES software, complete the Service and RX Tab fields using the following guidelines:

Service Tabs:

Step 1 Complete Service Tabs 1 and 2 as appropriate.

Step 2 Select Service Tab 3 and complete the appropriate fields.

Step 3 Enter Y in the RX Ind field to open the RX Tab.

RX Tab: Complete the following fields:

- NDC: Enter the 11-digit NDC number.
- Prescription Number: Not required.
- Units: Enter the units dispensed. Refer to the *Healthcare Common Procedure Coding System (HCPCS) Manual*; *Appendix 3*, for brief directions regarding the, Amount (Unit) column.

- Basis of Measurement: Enter IU (International Units); GR (Grams); ML (Milliliters); or UN for (Unit).
- Unit Price: Enter the price for the HCPCS medication dispensed.

See the *Provider Electronic Solutions (PES) Handbook; Section 9 (837 Professional Forms,)* for more information on completing the Rx fields.

Providers using vendor software other than PES will need to confirm with their vendor or clearinghouse that they have successfully tested the professional claim form with EDS and can successfully enter the required data into the correct fields (NDC of medication supplied, units dispensed, and basis of measurement for each HCPCS medication).

Paper Claims: Submission of an NDC Detail Attachment is required with paper claim forms when submitting a medication billed with a HCPCS code. For each medication HCPCS code, complete the corresponding detail line on the attachment with the NDC number, description, units dispensed, basis of measurement, and total charges. A copy of the NDC Detail Attachment is available in *Appendix D; Forms,* and can be used as a master copy.

Providers can avoid filling out the NDC Detail Attachment by submitting their claims electronically.

3.1.10 Mental Health (MH) Clinic Modifiers

Some procedure codes may require a modifier. Refer to the procedure code table listed for the specific modifiers needed.

3.1.11 Place-of-Service (POS) Codes

Enter the appropriate numeric code in the POS field on the CMS-1500 claim form or in the appropriate field of the electronic claim form.

11 Office.

99 Other - Community (used only when clinic services have been provided to an eligible homeless individual).

3.1.12 Specialized Services to Nursing Facility Participants

Psychotherapy may be provided to a participant residing in a nursing facility if the following criteria are met:

- The participant has been identified through the initial Pre-Admission Screening/Annual Resident Review (PASARR) process as being mentally ill.
- The participant has been identified through the PASARR level II screening process as requiring psychotherapy, as a specialized service.
- The participant, when informed of their options for service delivery, chooses a MH clinic to provide that service.
- The service is provided outside the nursing facility at a MH clinic.

Psychotherapy is:

- Supported by the independent evaluations completed and approved by DHW.
- Incorporated into the participant's medical care plan.
- Directed toward the achievement of specific, measurable objectives that include target dates for completion.

Regional Medicaid Services (RMS) offices are responsible for assuring the participant is identified as needing specialized services and for assigning prior authorization (PA) numbers for clinic services. The PA number must be included on the claim submitted for payment or the claim will be denied.

3.1.12.1 Procedure Codes for Psychotherapy

All claim forms for psychotherapy to nursing facility participants must include at least one of the following procedure codes:

Service	HCPCS or CPT Code	Description
Individual psychotherapy to nursing facility participants	**H0004** **U4** Modifier required	Behavioral health counseling and therapy, per 15 minutes. 1 Unit = 15 Minutes.
Individual interactive psychotherapy to nursing facility participants	**90899** **U4** Modifier required	Unlisted psychiatric service or procedure.
Group psychotherapy to nursing facility participants	**90853** **U4** Modifier required **U1** Modifier is required when provided by physician	Group psychotherapy (other than of a multiple-family group). 1 Unit = 15 Minutes.
Group interactive psychotherapy to nursing facility participants	**90857** **U4** Modifier required **U1** Modifier is also required when provided by physician	Interactive group psychotherapy. 1 Unit = 15 Minutes.
Family psychotherapy to nursing facility participants	**90847** **U4** Modifier required **U1** Modifier is also required when provided by physician	Family psychotherapy (conjoint psychotherapy, with patient present). 1 Unit = 15 Minutes.
Family medical psychotherapy without patient present to nursing facility participants	**90846** **U4** Modifier is required **U1** Modifier is also required when provided by physician	Family psychotherapy without patient present. Must be face-to-face with at least one family member present. The participant must be the focus of services. Goals of treatment must be specified on the participant's individualized treatment plan. 1 Unit = 15 Minutes.

3.2 Diagnostic Screening Clinic Service Policy

3.2.1 Overview

Diagnostic screening clinics coordinate the treatment between physicians and other medical professionals for Medicaid participants diagnosed with Cerebral Palsy, Myelomeningitis, or other neurological diseases and injuries with comparable outcomes. The clinic must be established as a separate and distinct entity from the hospital, physician, or other provider practices.

3.2.2 Multidisciplinary Assessment and Consultation

The clinic must perform an on-site multidisciplinary assessment and consultation with each participant and responsible parent or guardian. Diagnostic and consultation services related to the diagnosis and treatment of the participant are provided by board-certified physicians who are specialists in physical medicine, neurology, and orthopedics.

3.2.3 Service Limitations

As part of a diagnostic assessment, a medical social worker monitors and arranges participant treatments and provides medical information to providers who have agreed to coordinate the care of the participant. The clinic may bill no more than five hours of medical social services, per participant, during each state fiscal year (July 1 – June 30).

Note: Diagnostic screening clinic services are a covered benefit for Medicaid Enhanced Plan participants.

3.3 Claim Billing

3.3.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

Note: All claims must be received within 12 months (365 days), of the date of service.

3.3.2 Electronic Claims

For PES software billing questions, consult the *Provider Electronic Solutions* (*PES) Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software. See *Section 2 General Billing*, for more information.

3.3.2.1 Guidelines for Electronic Claims

Provider Number: In compliance with HIPAA and the National Provider Identifier (NPI) initiative beginning May 24, 2008, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

Detail Lines: Idaho Medicaid allows up to 50 detail lines for electronic HIPAA 837 Professional transactions.

Referral Number: A referral number is required on an electronic HIPAA 837 Professional transaction when a participant is referred by another provider. Use the referring provider's 9-digit Medicaid provider number, unless the participant is a Healthy Connections (HC) participant. For HC participants, enter the provider's 9-digit HC referral number.

Prior Authorization (PA) Numbers: Idaho Medicaid allows more than one PA number on an electronic HIPAA 837 Professional transaction. A PA number can be entered at the header or at each detail of the claim.

Modifiers: Up to four modifiers per detail are allowed on an electronic HIPAA 837 Professional transaction.

Diagnosis Codes: Idaho Medicaid allows up to eight diagnosis codes on an electronic HIPAA 837 Professional transaction.

National Drug Code (NDC) Information with HCPCS and CPT Codes: A corresponding NDC is required on the claim detail when medications billed with HCPCS codes are submitted. See *Section 3.1.8.1 Reporting National Drug Code (NDC) for Medications Billed with HCPCS Codes,* for more information.

Electronic Crossovers: Idaho Medicaid allows providers to submit electronic crossover claims for professional services.

3.3.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example*:* July 4, 2006 is entered as 07042006.

3.3.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MMDDCCYY) format. Note that in field **24A** (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field **24A**.
- You can bill with a date span (From and To Dates of Service) only if the service was provided every consecutive day, within the span.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be returned that are not signed unless EDS has a signature-on-file.
- Do not use staples or paperclips for attachments. Stack the attachments behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).
- Only one PA number is allowed for paper claims.
- When billing medications with HCPCS/CPT codes, an NDC, or NDC Detail Attachment must be filled out and sent with the claim.

3.3.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
PO Box 23
Boise, ID 83707

3.3.3.3 Completing Specific Fields of CMS-1500

Consult the, Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid Program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Note: Claim information should not be entered in the shaded areas of each detail unless specific instructions have been given to do so.

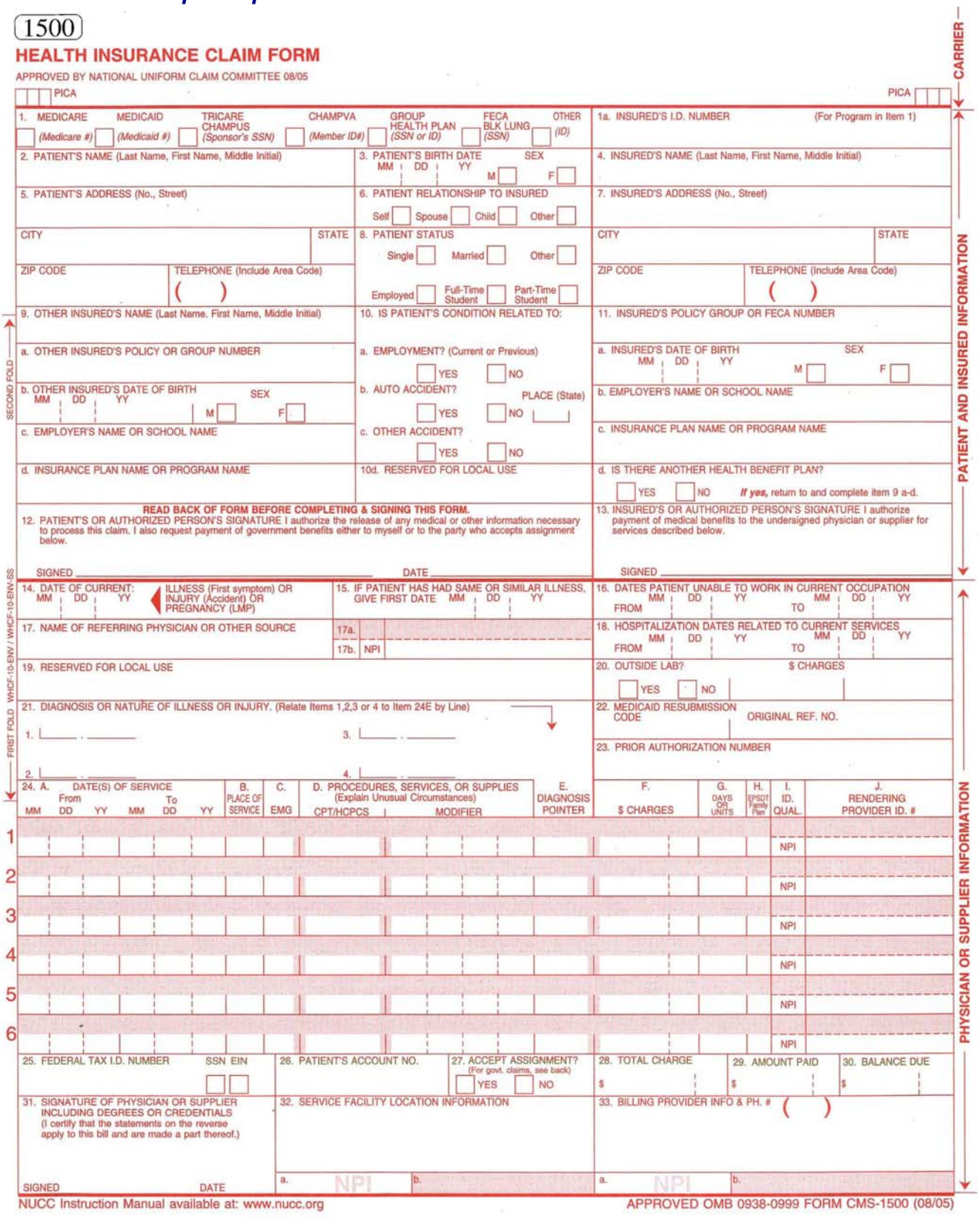
Field	Field Name	Use	Directions
1a	INSURED'S I.D. NUMBER	Required	Enter the participant's 7-digit Medicaid identification (MID) number exactly as it appears on the MAID Card.
2	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Required	Enter the participant's name exactly as it is spelled on the participant's MAID card. Be sure to enter the last name first, followed by the first name, and middle initial.

Field	Field Name	Use	Directions
9a	OTHER INSURED'S POLICY OR GROUP NUMBER	Required, if applicable	Required, if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the policy number.
9b	OTHER INSURED'S DATE OF BIRTH/SEX	Required, if applicable	Required, if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	EMPLOYER'S NAME OR SCHOOL NAME	Required, if applicable	Required, if field **11d** is marked yes.
9d	INSURANCE PLAN NAME OR PROGRAM NAME	Required, if applicable	Required, if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	IS PATIENT'S CONDITION RELATED TO EMPLOYMENT?	Required	Indicate Yes or No, if this condition is related to the participant's employment.
10b	IS PATIENT'S CONDITION RELATED TO AUTO ACCIDENT?	Required	Indicate Yes or No, if this condition is related to an auto accident.
10c	IS PATIENT'S CONDITION RELATED TO OTHER ACCIDENT?	Required	Indicate Yes or No, if this condition is related to an accident.
11d	IS THERE ANOTHER HEALTH BENEFIT PLAN?	Required	Check Yes or No, if there is another health benefit plan. If yes, return to and complete items **9a** - **9d**.
14	DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	Required, if applicable	Use this field when billing for a consultation or HC participant. Enter the referring physician's name.
17a	BLANK FIELD	Required, if applicable	Use this field when billing for consultations or HC participants. For consultations enter the qualifier **1D** followed by the referring physician's 9-digit Idaho Medicaid provider number. For HC participants, enter the qualifier **1D** followed by the 9-digit HC referral number. **Note**: The HC referral number is not required on Medicare crossover claims.
17b	NPI	Not required	Enter the referring provider's 10-digit. National Provider Identifier (NPI). **Note:** The NPI number, sent on paper claims, will not be used for claims processing.

Field	Field Name	Use	Directions
19	RESERVED FOR LOCAL USE	Required, if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the Internal Control Number (ICN) of previous claims to establish timely filing.
21 (1 - 4)	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Required	Enter the appropriate ICD-9-CM code up to four, for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	PRIOR AUTHORIZATION NUMBER	Required	If applicable, enter the PA number from Medicaid, DHW, RMS, ACCESS, RMHA, QIO, or MT.
24A	DATE(S) OF SERVICE FROM/TO	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). Example: November 24, 2003, becomes 11242003 with no spaces and no slashes.
24B	PLACE OF SERVICE	Required	Enter the appropriate numeric code in the place of service box on the claim.
24C	EMG	Required, if applicable	If the services performed are related to an emergency, mark this field with an X.
24D 1	PROCEDURES, SERVICES, OR SUPPLIES; CPT/HCPCS	Required	Enter the appropriate 5-character CPT/HCPCS procedure code to identify the service provided.
24D 2	PROCEDURES, SERVICES, OR SUPPLIES; MODIFIER	Desired	If applicable, add the appropriate CPT/HCPCS modifier(s). Enter as many as four. Otherwise, leave this section blank.
24E	DIAGNOSIS POINTER	Required	Use the number of the subfield **1** - **4** for the diagnosis code entered in field **21**.
24F	$ CHARGES	Required	Enter the usual and customary fee for each line item or service. Do not include tax.
24G	DAYS OR UNITS	Required	Enter the quantity or number of units of the service provided.
24H	EPSDT FAMILY PLAN	Required, if applicable	Not required unless applicable. If the services performed constitute an Early Periodic Screening Diagnosis and Treatment (EPSDT) Program screen, see *Section 1.6 EPSDT*, for more information.
24I	ID. QUAL.	Required, if applicable	Enter qualifier **1D** followed by the 9-digit Idaho Medicaid provider number in **24J**.
24J	RENDERING PROVIDER ID. #	Required, if applicable	Enter the 9-digit Idaho Medicaid provider number in the shaded portion of this field if the **1D** qualifier was entered in **24I**. **Note:** If the billing provider number is a group, then paper claims require the 9-digit Idaho Medicaid provider number of the performing provider in the Rendering Provider ID. # field. **Note:** Taxonomy codes and NPI numbers, sent on paper claims, will not be used for claims processing.
28	TOTAL CHARGE	Required	The total charge entered should be equal to all of the charges for each detail line.

Field	Field Name	Use	Directions
29	AMOUNT PAID	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	BALANCE DUE	Required	Balance due should be the difference between the total charges minus any amount entered in the amount paid field.
31	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See *Section 1.1.4 Signature-on-File Form*, for more information.
33	BILLING PROVIDER INFO & PH. #	Required	Enter the name and address exactly as it appears on the provider enrollment acceptance letter or Remittance Advice (RA). **Note:** If you have had a change of address or ownership, immediately notify Provider Enrollment, in writing, so that the provider master file can be updated.
33A	NPI	Desired, but not required	Enter the 10-digit NPI number of the billing provider. **Note:** NPI numbers, sent on paper claims are optional and will not be used for claims processing.
33B	BLANK FIELD	Required	Enter the qualifier **1D** followed by the provider's 9-digit Idaho Medicaid provider number. **Note:** All paper claims will require the 9-digit Idaho Medicaid provider number for successful claims processing.

3.3.3.4 Sample Paper Claim Form



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HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name. First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH. # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS